Revocation of Authorization to Disclose Health Information

I want to cancel the permission I gave to share my health information with this person or group:

Recipient Information:

Name (person/group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) ____ - _____

Authorization Signed Date (if known): _____/_____/_____

Member Information:

Member Name (print): _____

Member Date of Birth: _____/_____/_____ Member Medicaid ID Number/Member ID#: _____

I know that my health information may have already been shared because of the permission I gave before. I also know that this cancellation only applies to the permission I gave to share my health information with this person or group. It does not cancel any other authorization forms I signed for health information to be shared with another person or group.

Member Signature: _____ **Date**: ____/____/_____
(Member or Legal Representative Sign Here)

If you are signing for the Member, describe your relationship below. If you are the Member's personal delegate, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

_____
_____

The plan will stop sharing your health information when we get this form. Use the mailing address below. You can also call for help at the number below.

coordinated care™

Coordinated Care - Compliance Department
1145 Broadway, Suite 300
Tacoma, WA 98402
Member Services: 1-877-644-4613
Fax: 1-877-644-4602